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ABSTRACT

The first year of operation of the Eufaula Adjustment Center, a residential facility of the Alabama Department of Mental Health, is described and evaluated in this report. The Center's approach is based on the concept that certain mental illnesses are the result of having learned inadequate or inappropriate coping skills and behavior rather than disease. The staff, largely nonprofessionals previously inexperienced in the field of mental health care, are selected and trained by the Center to help residents unlearn negative responses and learn new more socially and personally supportive behavior. The residents, primarily young adults, progress at their own rate through individualized programs featuring courses in vocational and personal development, individually prescribed instruction (IPI), and physical education, and recreational activities. The Center operates a token economy system with reinforcement for positive behavior. The Department of Mental Health was assisted in the development of training and treatment programs by the Human Resources Research Organization (HumRRO). (Author)

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The Eufaula Adjustment Center: A Progress Report

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Eufaula Adjustment Center

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Human Resources Research Organization

A joint report by:

State of Alabama
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Montgomery, Ala.

Human Resources
Research Organization
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FOREWORD

This report summarizes the mental health treatment program and related activities of the Eufaula Adjustment Center, Eufaula, Alabama, during its first year of operation. The Center is a residential institution of the Alabama Department of Mental Health. The treatment programs of the Center differ from many traditional mental health programs in that the Center's programs are based on the premise that adjustment problems are learned behaviors rather than illnesses.

Much of the information contained in this report was presented as a Program Report at the meeting of the Southeastern Psychological Association in New Orleans, Louisiana, in April 1973. That program, which was titled "The Eufaula Adjustment Center: Program Report on a Center for the Treatment of Maladaptive Behaviors," was chaired by Waters C. Paul, the Director of the Center. Presentations were: "Mission and History of the Eufaula Adjustment Center," by Waters C. Paul; "The Treatment Program," by John Meads, III; "The Token Economy," by Alton Land, Jr; "Treatment Program Effectiveness," by Connie C. Jones; "Staff Training," by John Bilbrey; and "Communication with Potential Residents and Referral Sources," by Paul W. Caro.

The work described in this report was performed at the Eufaula Adjustment Center. During the period February 1972 through September 1973, the Human Resources Research Organization has been under contract to the Department of Mental Health to assist the Center's Director principally in the development of staff competencies required for the operation of the Center and in the organization and establishment of the Center's treatment programs. Dr. Paul W. Caro has directed the HumRRO efforts, and he has been assisted by Dr. John Bilbrey, Mr. H. Alton Boyd, and Mrs. Kay U. Paulk. All are from HumRRO Division No. 6, Dothan, Alabama, which is directed by Dr. Wallace W. Prophet.

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Charles L. Aderholt
Commissioner of Mental Health
State of Alabama

Meredith P. Crawford
President
Human Resources Research Organization

SUMMARY AND CONCLUSIONS

The Eufaula Adjustment Center is a residential facility for young adults with multiple, complex social, and personal maladaptive behavior problems. Its treatment programs are based upon the premises that many or most "mental health problems" are not the result of disease or disordered mental processes, but are the products of an individual's having learned inadequate or inappropriate behaviors, and that these difficulties in coping with life situations are best ameliorated through the same basic processes by which they are created--that is, learning.

The Center, which has been in operation since April 1972, is operated by the Alabama Department of Mental Health. Its first year of operation has been a period of organization, program development, and staff training. During that period, the Human Resources Research Organization has been under contract to the Department to assist the Center's Director in these activities. The present report describes the Center's programs and underlying rationale as they were at the end of that period.

TREATMENT PROGRAMS

The treatment programs at the Eufaula Adjustment Center are based on the following common principles:

- Maladaptive behaviors are learned and can be modified through learning processes.
- Behavior can be quantified, and changes in behavior can be documented in quantifiable terms.
- Treatment goals should involve behaviors that will be useful and will be maintained in the environment to which residents will return at the conclusion of treatment.
- Programs should be individualized to meet the needs of individual residents.
- Programs should be changed if the data do not indicate that intended changes in behavior are occurring.

These principles have been applied in the development of the Center's intensive, short-term behavior change programs. The primary goal toward which each program is directed is the return of a resident to the community as a productive citizen in as short a time as possible.

The Center is organized much like a small school. There are class levels through which residents are promoted as they progress through treatment. A "core curriculum" of commonly required activities constitutes a significant proportion of all residents' programs. In addition, a number of "short courses" provide small group instruction in social and personal skills that are lacking in many of the residents because of the limited learning opportunities they have had prior to entering the Center. Behavior therapies such as assertive training and desensitization are provided on individual and small group bases when required. These intensive treatment activities occupy approximately eight hours per day, five days per week, of the residents' time. During the remaining "free time," activities that foster social interaction and leisure time management are provided for their voluntary participation.

All programs are individualized in recognition of the unique nature of the adjustment problems presented by the Center's residents. When a resident enters the Center, he and a senior staff member identify his behavior problems, decide upon behavior change goals, develop program plans, and write instructions to other staff members concerning

the conduct of the resident's program. Residents participate in all discussions and staff conferences concerning their behavior change goals and program activities. All data and records concerning a resident's progress are available to him for review at any time.

The Center operates on a token economy. Residents are awarded tokens for activities that lead to or reflect progress toward their behavior change goals. The tokens in turn can be used to purchase meals, recreational activities, items in the canteen, and other desirable rewards for efforts expended.

STAFF DEVELOPMENT

While any health care organization generates staff development requirements, most depend upon outside educational institutions to provide them with professional or paraprofessional personnel already trained to administer its treatment program. The Eufaula Adjustment Center, however, employs persons essentially untrained and inexperienced in mental health or behavior science areas. The training they receive at the Center is designed to develop staff treatment competencies just as the Center's overall program is designed to develop its residents' adjustment competencies. Except for the Center's Director, none of the staff had previous training or experience that would qualify him as a mental health professional or paraprofessional.

Since all employees at the Center have contact with residents, training in learning-based behavior change technologies is required for all of them. In the case of those whose primary function is supportive (e.g., secretaries, maintenance personnel, and cooks), training is aimed at familiarization with treatment approaches, but in addition, each such employee is trained to be an objective observer of resident behaviors and a source of behavioral data concerning them.

Training for staff members whose duties are more directly related to the development and management of residents' programs is more intensive. It consists of instruction in the principles of learning-based behavior change techniques and the application of those techniques at the Center through lectures, discussions, and conferences with staff members, audiovisual presentations, workshop exercises, reading assignments, observation of on-going treatment activities, conduct of behavior change projects, and supervised work in the treatment program itself. The techniques of individual behavior therapies, such as behavioral counseling, assertive training, relaxation, and desensitization, are included in the staff training program. All training is designed for administration to groups or to individuals on an individually paced basis.

PROGRAM EFFECTIVENESS

Between April 1972 and March 1973, 63 residents were admitted to the Eufaula Adjustment Center. As of March 1973, 46 of the 63 residents had been discharged from the Center or 2 had completed their programs and were awaiting discharge; 17 were in active programs. Of the 46 residents who were no longer in active treatment programs, 9 either refused or were unable to participate in program activities. Thus, after almost one year of operation, 37 residents had been or were awaiting discharge after participating in program activities in accordance with their treatment plans.

On the basis of an Improvement Index derived from an analysis of behavior problem data, 18 of those residents were classified as "much improved," 10 were "moderately improved," and 9 were "unimproved."

The 37 residents who had completed their programs included 22 males and 15 females. Program effectiveness appeared to be unrelated to sex.

The range of ages was from 14 to 51 years, although 26 of these 37 residents were within the 18-35 age range. Program effectiveness in general appeared to be unrelated to age.

Educational levels of the 37 ranged from no formal education through college; 18 had not completed the sixth grade, 10 had left school between the sixth and ninth grades, and 9 had completed ninth grade or higher. There appeared to be a relationship between educational level and training program effectiveness, with the program being more effective for the residents at lower educational levels. There also appeared to be a relationship between referral source and program effectiveness, but referral source and educational level are closely related because so many of the initial residents came to the Center from a school for a presumed mental retardate population where educational opportunities were limited.

Review of the data concerning behaviors most and least amenable to change in the Center's program suggested a few tentative guidelines for program modification. Using the limited data available from the initial 63 residents, it appears that behaviors most amenable to change following treatment at the Center involve inappropriate rationalization and inappropriate body/limb movement. Behaviors most resistant to treatment at the Center during this initial period involve drug-related behaviors and aggression. A more detailed profiling of successfully and unsuccessfully treated behaviors could not be developed without additional data.

CONCLUSIONS AND PROGRAM CHANGES

The Eufaula Adjustment Center's program, after more than a year of operation, has been generally successful in returning residents to their communities better able to cope with their problems, and with more understanding of how to deal with those they encounter in the future.

To further improve the program, efforts are being made at the Center in the direction of expanding services to include a wider range of treatment activities, particularly at the community level. This expansion is a reflection of the present philosophy of the Alabama Department of Mental Health: to move toward the development of community alternatives to hospitalization and institutionalization. Accordingly, the Center has shifted more of its resources to the application of treatment concepts to the behavior problems of non-residents. Four areas of such community-oriented activity have been, or will be, initiated: Day Care Programs, Community Placement and Follow-Up, Community Information and Training, and Crisis Intervention.

The basic approach of the Center's program has not changed. The concepts that maladaptive behaviors are learned responses to an individual's environment rather than manifestations of disease, and that difficulties in coping with some of life's troublesome situations can be best ameliorated through learning processes, are borne out by the Center's experience. These concepts will guide the Center's activities while the search continues for other approaches and techniques that might provide further improvements in these treatment areas.

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The Eufaula Adjustment Center: A Progress Report

Chapter 1

BACKGROUND AND CONCEPTS

INTRODUCTION

The Eufaula Adjustment Center is a therapeutic community operated by the Alabama Department of Mental Health. The residents it serves consist of young adults with multiple, complex, social and personal maladaptive behaviors. In meeting the needs of this clientele, the Center adheres to the approach that views an individual's adjustment problems as learned behaviors rather than illnesses.

The Center began accepting residents in April 1972. In its first year of operation, efforts were directed toward developing treatment programs for these residents based upon behavior change technology, and toward training staff personnel in the administration of these programs. During this period, the Human Resources Research Organization was under contract to the Department of Mental Health to aid in the development of the treatment programs, the development of staff competencies, and the development of the general organization of the Center's resources to deliver services to its residents.

The present report presents the rationale and approach taken in the Eufaula Adjustment Center's developmental work, describes the management and planning of the individual treatment programs, discusses the concepts and activities connected with staff development, and discusses changes in the Center's activities which reflect the philosophy of the Department of Mental Health to move toward further development of community alternatives to hospitalization. Also included in this report is a preliminary evaluation of the Center's overall effectiveness during the initial 11 months of operation.

CONCEPTUAL APPROACH

The general concepts on which the Eufaula Adjustment Center is based offer much promise as an effective means of meeting certain mental health needs. At the heart of the Center's program are the premises that many or most "mental health problems" are not the result of disease or disordered mental processes, but are the products of an individual's having learned inadequate or inappropriate behaviors, and that these difficulties in coping with life situations are best ameliorated through the same basic process by which they are created—that is, learning.

This learning model of behavior etiology and therapeutic change has only recently attracted widespread attention, and the Eufaula Adjustment Center is one of the first mental health institutions to base its treatment programs solely upon it. The principal feature of the learning model is that it focuses upon behavior. Its content is the activity of an individual as he interacts with his environment. This emphasis upon activity in its environmental context orients treatment considerations toward an individual's observable behavior rather than toward underlying disorders. Thus, when maladjustment is viewed as a learned pattern of improper behavior brought about by environmental circumstances and consequences, more suitable patterns of behavior can be developed through training the individual to interact differently with his environment.

In the therapeutic application of the learning model to the modification of behavior at the Center, maladaptive behaviors are identified and quantifiable data describing them are recorded. Goals are set specifying the degree of change which must occur with respect to such behaviors, and behavior training or "treatment" programs are devised to bring about the goal behavior. Instruction or "prescriptions" are written to various staff personnel who will undertake the required treatment activities, and gather data describing

In applying the learning model to modify behavior, Center staff members identify maladaptive behaviors and record descriptions.*

the behavior changes which occur. When the goal behavior is attained, the treatment program terminates. In some instances, the treatment program may also include modification of an individual's environment as an aid to attainment of his behavior change goals.

In contrast to this learning model approach to the modification of maladaptive behavior, traditionally individuals experiencing emotional, social, and vocational adjustment problems have been subjected to psychiatric treatment to deal with an assumed underlying cause of those problems. Such individuals were considered "sick," and it was the responsibility of a medically oriented facility to "cure" the symptoms presented through attacking the causes of those symptoms. Those who hold this traditional view typically "treat" individuals from a symptom position with the inherent idea that they are sick and incapable of making choices concerning their own treatment. This sickness orientation often involves reliance upon medication as a principal treatment approach, and treatment programs tend to follow predetermined lines, with each subsequent step occurring only after a particular phase has been completed. After a degree of improvement, the individuals might be placed in a sheltered situation to strengthen their social coping skills. When they are judged ready by an independent expert or board of experts, they might be placed in a predetermined vocational setting to pursue the vocational objectives selected for them. These settings are considered consistent with patients' adjustment status, but are frequently ones which the individuals involved have little or no motivation to pursue.

The Eufaula Adjustment Center is a facility whose program is founded on concepts in marked contrast to these traditional philosophies. The residents—those who come to

*Wherever individuals are recognizable in the photographs used to illustrate Center activities, members of the staff have posed for the pictures.

the Center are called "residents," not "patients," to emphasize to them that they are not viewed as ill in the traditional sense—accept the fact that they have adjustment difficulties, that is, that they engage in behaviors which are not personally or socially acceptable. They voluntarily enter the Center seeking help with those difficulties. Individuals are not authoritatively thrust into specific, predetermined programs with fixed sequences of treatment activities. Rather, staff members instruct newly arrived residents in the relationships between their behavior and the environmental factors influencing that behavior, and discuss the Center's therapeutic processes and resources with them. Together, they establish specific behavior change goals, and treatment activity selections are made jointly. The residents become therapeutic agents in their own individualized treatment programs, which may be altered or modified as they progress toward goals. The focus is on learning appropriate and effective behaviors, and modifying, through learning processes, inappropriate and ineffective behaviors, not upon more traditionally oriented therapies.

All activities and programs at the Center, whether individual, educational, social or vocational, are viewed as having potential therapeutic value. Each of these activities provides opportunities for residents to engage in and acquire skill at the performance of individually and socially appropriate behaviors under close staff supervision and guidance. In this manner, residents at the Eufaula Adjustment Center are living 24 hours a day, in an environment that elicits, shapes, and strengthens behaviors critical to effective interpersonal adjustments.

The wide variety of treatment programs offered at the Center requires a staff which is trained to perform many program tasks. Consequently, a major factor in the conceptualization of the Center's program relates to manpower. There is a growing realization that traditional methods of mental health care services are failing to meet society's requirements—not only because they are basically inadequate in that they do not recognize the learning basis of many behavior problems, but also because they demand highly skilled professional personnel in numbers that our educational institutions cannot hope to supply. As a means of solving this problem, the Center's approach is to rely upon behavior change techniques which can be employed successfully by persons who are not mental health professionals.

While any health care organization generates staff development or training requirements of one sort or another, most depend on outside educational institutions to provide them with professional or paraprofessional personnel who already are trained to function within a health care environment. In the case of the Eufaula Adjustment Center, however, the Center itself provides the necessary training to persons essentially untrained and inexperienced in mental health or behavioral science areas, and places a premium on its own ability to train its staff members.

A staff training program has been developed to train non-mental health professionals to adapt the Center's treatment approach and resources to the needs of its resident population. The training program is designed to develop staff treatment competencies just as the Eufaula Adjustment Center's overall program is designed to develop the residents' adjustment competencies.

FACILITIES AND ADMISSIONS

The Eufaula Adjustment Center occupies the site of a former Air Force radar base. Through a program of renovation, it has been converted to a training center much like a small college campus. There are dormitories for men and women residents, a dining hall, buildings housing classrooms and various training and evaluation activities, and a canteen

The Eufaula Adjustment Center occupies the site of a former Air Force radar base, converted to a training center much like a small college campus.

with merchandise for residents to purchase. One of the changes made at the Center was to remove the gates that guarded the entrance to the old radar site. Since everyone at the Center is there only because he wants to be, there is no need for gates and guards.

Admission to the Center is open to residents of Alabama, regardless of race or sex, who are between the ages of 18 and 35 and who, except for the behavior problems which bring them to the Center, are judged to have the potential to become productive citizens. Residents must be capable of functioning at near-average levels of intelligence and must be literate; that is, they should have at least a 4th grade education. They must be employable, or presumably employable, following treatment and vocational training. They must be in good physical health. Since the Center is not a medical facility, and there are no physicians on the staff, all residents must be able to sustain themselves without constant medical attention. These admission criteria are flexible, however.

The chief criterion is that admission must be voluntary. There are no exceptions to this requirement. Thus, one cannot be committed to the Center by a court, and no person having court charges or any formal court holding pending criminal action is eligible. With regard to minors, the parents or guardian's consent is required for admission, but no minor can be forced to enter the Center through such action. Further, individuals who might be unable to cooperate voluntarily in the Center's activities due to their psychiatric status or psychopathic orientation are excluded.

Chapter 2

TREATMENT PROGRAMS[1]

APPROACH

The programs for residents at the Eufaula Adjustment Center are based on the following common principles:

(1) Maladaptive behaviors are learned and can be modified through learning processes.

(2) Behavior can be quantified, and changes in behavior can be documented in quantifiable terms.

(3) Treatment goals should involve behaviors that will be useful and will be maintained in the environment to which residents will return at the conclusion of treatment.

(4) Programs should be individualized to meet the needs of individual resident.

(5) Programs should be changed if the data do not indicate that intended changes in behavior are occurring.

The first of the principles, the learning model underlying the Center's program, has been discussed in Chapter 1. With respect to the second principle concerning quantification of behavior, heavy reliance is placed upon determination of the frequency and measurable intensity or magnitude of behavior. Treatment programs at the Center are designed to deal directly with these factors, for example, to reduce the frequency of a particularly offensive interpersonal behavior to zero or to an acceptably low level of occurrence, or to increase the frequency of a more adaptive competing behavior.

Since all treatment programs are, in effect, training programs designed to bring about specific behavioral skills, the need to identify specific goals, as is indicated in the third principle, is obvious. As a practical matter, the behavior goals selected are those behaviors which will be most readily welcomed by society when residents leave the Center. Since the maladaptive behaviors that bring residents to the Center vary widely, their goals do likewise; hence, as the fourth principle indicates, programs must be responsive to those individualized goal requirements. Consistent with the empirical approach implied by the fifth principle, whether a program is in fact responsive is determined by the measurable changes that occur with respect to a resident's goal behavior.

These principles have been applied in the development of the Center's intensive, short-term behavioral change programs. The primary goal toward which each program is directed is the return of a resident to the community as a productive citizen in as short a time as possible.

PROGRAM ORGANIZATION

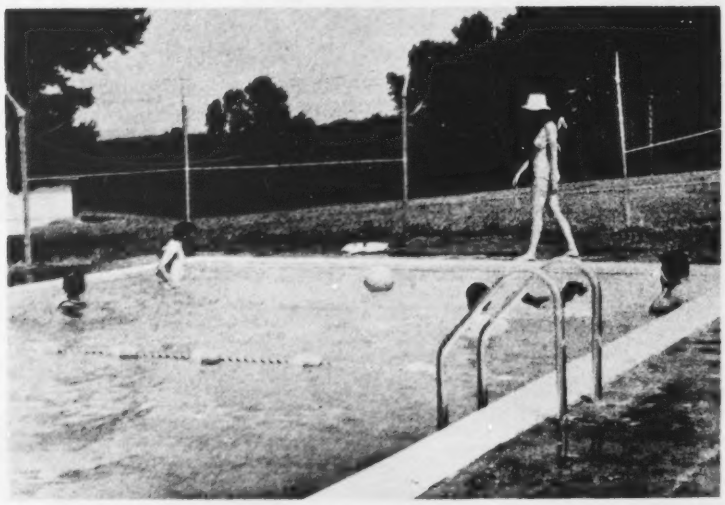
The Center is organized much like a small school, rather than like a hospital. There is a system of levels through which residents progress during their treatment. Entering

[1] This chapter includes material presented by John Meade, III, and Alton Land, Jr., in a Program Report at the meeting of the Southeastern Psychological Association in April 1973. For a complete citation, see the Foreword to this report.

residents begin on Level I and progress to Levels II, III, and IV. By the time a resident is promoted to Level IV, most of his treatment programs have been completed, and he is nearing discharge. Level V is reserved for residents who have completed treatment and are waiting for vocational placement or for specific arrangements to be made for their return to the community.

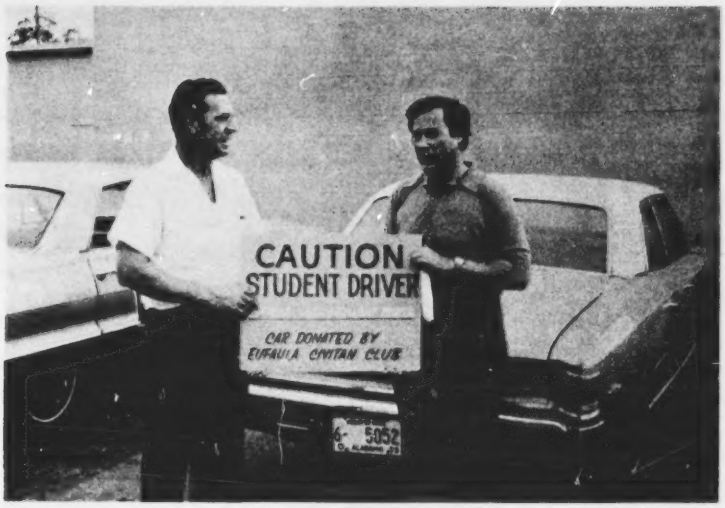
Most of the program activities take place at the intermediate levels, and residents are promoted from one level to another largely in recognition of their progress. Various privileges, such as access to nearby communities, are associated with each achievement level, so that promotion from one level to another is itself reinforcing to the resident concerned.

Although each resident's program is individualized, there are a number of activities that fulfill treatment needs of almost all of the Center's residents, and a "core curriculum" is available to facilitate conducting and scheduling these commonly needed activities. The core curriculum consists of individually prescribed academic instruction to make up academic deficiencies that interfere with social and work adjustment; physical education training for the dual purpose of physical exercise and supervised social interaction within a structured game situation; and vocational assessment and pre-vocational training experience that not only deal with deficits in the vocational area, but also provide structured situations in which interpersonal behaviors within an employment context can be shaped.



The core curriculum includes physical education training, to provide both physical exercise and supervised social interaction.

In addition to this core curriculum, small group instruction and training courses of from one to three weeks duration—called "short courses"—are available for residents with personal skill deficiencies. Their objectives are to train residents to cope more effectively with the everyday situations faced by individuals living alone or with their own families. The subject matter of the short courses includes driver education, personal grooming, sex education, home nursing, leisure time management, meal planning and cooking, and money management. The behavioral deficits for which the short courses are designed in some cases may reflect limited ability on the resident's part. More often, however, the deficits are consequences of the limited learning opportunities afforded poorly adjusted individuals in their homes and communities or in the institution from which they came.



The subject matter of the short courses includes driver education.

Many of the adjustment problems of the Center's residents require different or more intensive treatment than can be afforded in the individual and group activities described above. Therefore, in addition to attending core curriculum and short course activities prescribed by their program, each resident meets individually and in small groups with senior treatment staff personnel to whom they are assigned for more intensive assistance when required. During these sessions, learning-based techniques, widely known as behavior therapy, are employed. These techniques, including behavioral counseling, assertive training, and desensitization, enable the staff to deal with residents' problems such as depression, anxiety, overly aggressive or submissive behavior, phobic behavior, and ineptness in interpersonal relations. During these activities, techniques such as modeling and role playing, sometimes using the Center's television recording and playback facilities, are often employed to provide feedback to residents concerning their behavior and its consequences.

Each resident meets, individually and in small groups, with senior treatment staff personnel for more intensive assistance when needed.

Television recording and playback facilities are often used to provide feedback to residents about their behavior and its consequences.

In the application of the learning model to the modification of behavior during these treatment activities, staff emphasis is upon identifying appropriate residents' behaviors and assuring that the consequences of those behaviors are such that they will be more likely to recur. Thus, efforts are made to identify and reward the residents' more desirable behaviors whenever they occur. An almost unlimited supply of positive rewards, or reinforcers, is available for that purpose at the Center when residents engage in appropriate behaviors consistent with their treatment goals. Certain basic reinforcers—for example, food—are under the control of the Center's token economy which is described below. Other reinforcers—for example, peer approval—occur as a natural consequence of successful social interaction in prescribed treatment activities.

While the emphasis is on assuring positive consequences for appropriate behavior, negative consequences sometimes are a result of inappropriate behavior. Punishment, in the form of time-out periods during which positive reinforcing items and activities are not available to a resident, is employed, although sparingly, in some cases. Other forms of punishment, such as aversive conditioning, are seldom used and then only with the resident's informed consent and in treatment programs where experimental evidence indicates clearly that such techniques are the most effective way of dealing with a specific maladaptive behavior.

These activities generally are scheduled between 8:00 a.m. and 5:00 p.m., Monday through Friday, and residents typically are scheduled to attend up to eight hours of therapeutic activities each day. In the evenings, group and individual social and recreational activities are available, and the residents are encouraged to participate in the activities of their choice. Each activity is directed by a staff member and is structured to encourage appropriate social or cooperative work behavior on the part of the participating resident. The facilities available in the evenings include a TV lounge, a social hall where dances and games are conducted, a pool hall, a canteen with juke box and pin ball machines, and a crafts center. In addition, the residents publish a weekly newspaper, and work on it is done during the evenings.

These same free-time activities are available on weekends. In addition, the Center's buses are used on weekends for trips to town, to a near-by recreational center, and for sight-seeing purposes. The availability of these off-Center activities is generally limited to residents at upper treatment levels, but the activities also can be made available to

residents at lower levels as reinforcers for particular achievements toward their behavior change goals. When such visits would be consistent with a resident's treatment program, he might also be encouraged to visit home on the weekends.

DEVELOPMENT AND MANAGEMENT OF INDIVIDUAL PROGRAMS

When a resident enters the Center, behavioral and available case history data are used to develop a list of his or her behavior problems. All subsequent treatment activities center around this problem list. The chief treatment program management tool is a record system which provides, on a continuing basis, data describing progress toward treatment goals.

The treatment program is managed through a record system that provides a continuing description of progress toward treatment goals.

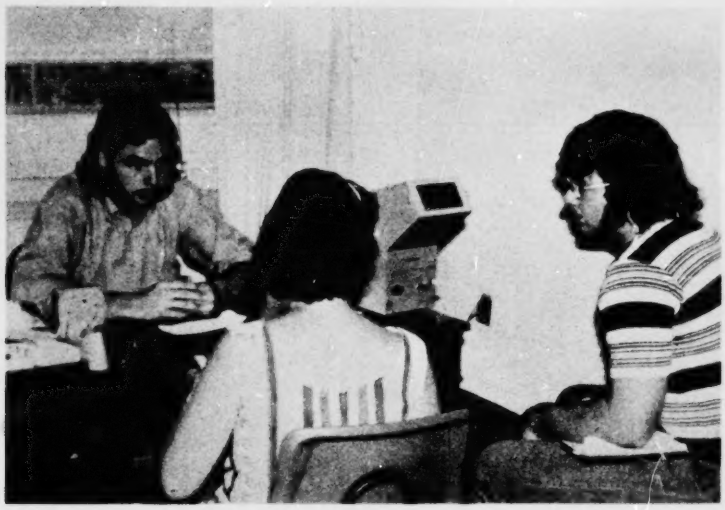
For each behavior problem, a unique treatment plan is developed and recorded in the resident's record, and prescriptions for the execution of treatment activities consistent with each treatment plan are prepared. These prescriptions are communications addressed to specific staff members and constitute instruction for the conduct of required treatment activities.

Treatment plans continue to be developed and executed for a particular behavior problem until that problem no longer exists, that is, until the maladaptive behavior has been appropriately modified or until the specified behavioral deficit has been corrected. This procedure is followed until all observed behavior problems can be closed. Behavior problems are closed by indicating in the resident's record that specified treatment goals have been reached and that the previously identified maladaptive behaviors or behavioral deficits no longer exist.

An important part of the interstaff communication associated with the Center's behavior change program is the "Current Note." Whenever any staff member observes a resident engaging in a behavior, adaptive or maladaptive, which he wishes to bring to the attention of the staff member responsible for a particular resident's treatment program, he writes or dictates a description of that behavior, the circumstances surrounding it and its consequences, and any additional explanatory comments he may wish to make. These Current Notes are entered daily into the resident's records and constitute an important

and continuing source of behavioral data concerning the frequency and circumstances of various behaviors under treatment. They also serve the important purpose of calling attention to previously undetected maladaptive behaviors for which treatment plans need to be developed.

A requirement of the Center's program is that each resident and the staff member responsible for the development of his treatment plan must concur on the intended treatment goals and procedures affecting him. To the extent possible, residents are required to participate in all discussions and staff conferences concerning their behavior change goals and treatment activities. All data and records concerning a resident's own treatment program and progress are available for his review at any time. In fact, duplicate copies of all of his problem lists, treatment plans, prescriptions, and current notes are maintained at convenient locations for the resident's unlimited access.



Residents take part in all discussions and staff conferences about the goals for their behavior change and the treatment activities.

TOKEN ECONOMY PLAN

To facilitate the award of reinforcers to residents whenever they engage in behavior consistent with their treatment goals and to encourage their participation in prescribed treatment activities, the Eufaula Adjustment Center program operates on a token economy basis. In a token economy, individuals may earn tokens (credits) as rewards for engaging in appropriate behaviors. The tokens then may be exchanged for meals, items in the canteen, or other things having intrinsic value. While reinforcers having intrinsic value tend to be difficult to administer in many situations, tokens can be dispensed with relative ease. A properly designed and managed token economy is an effective means for managing the behavior of the members of a group. (The monetary systems of most governments can be viewed as token economy systems.)

The medium of exchange at the Center, instead of a token per se, is an intangible point. Residents may earn points by attending and participating in prescribed activities, and by acting appropriately in various treatment and non-treatment situations. They can spend these points to acquire the items and privileges that in other communities would be acquired with money. Residents can purchase nothing with money on the premises.

Tokens earned by residents may be exchanged for meals, items in the canteen, or other items of value.

When a resident enters the Center, he is given a point card with his name and file number on it. The card is filled with blocks marked with various point denominations, or values, from 1 to 25. When he earns one or more points, the appropriate blocks on his point card are validated by being initialed and dated by a staff member. Any staff member may give points in this manner when he observes a significant behavior which he knows to be consistent with a resident's behavior change goals. Thus, token reinforcers are almost constantly available to residents when behavior is appropriate, and the residents making the more rapid progress toward their behavior change goals will earn more points to spend.

When a staff member awards points, he makes a record of the award on a Point Tally Sheet. When an item or privilege is purchased with points, the staff member supervising the activity involved punches a hole in the number of initialed blocks on the resident's point card corresponding to the "cost" and makes a record of the transaction on a Point Charge Sheet. At the end of each day, all Point Tally Sheets and all Point Charge Sheets are turned in to the Records Office, where the number of points earned and spent by each resident is compiled and recorded. This procedure provides a current picture of the amount and kind of reinforcement each resident receives each day, and of the particular behaviors being reinforced.

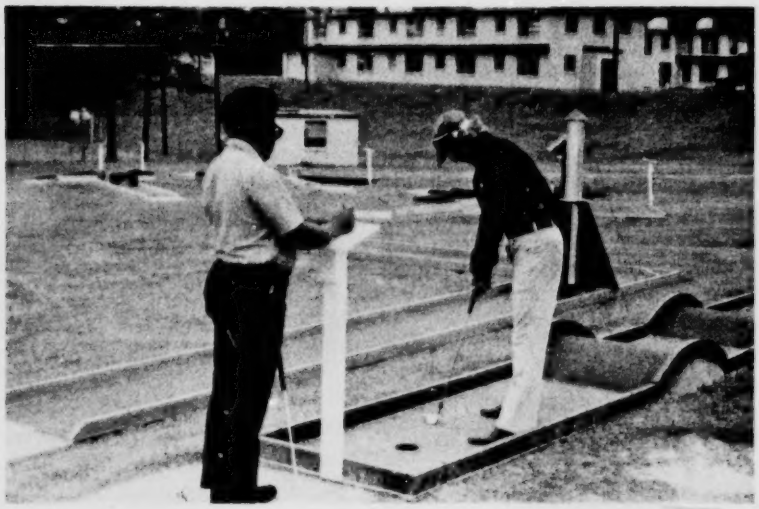
The usual rate of pay for the desired behavior is one point for each hour spent in a prescribed treatment activity, although the rate can be adjusted in accordance with a given resident's program. Additional points may be earned for above average participation or for exhibiting a specific, desired behavior. For instance, if a resident with an identified problem of frequent negative verbalizations makes a specified number of positive statements, he may receive supplemental points for his more appropriate behavior. Other residents may earn additional points by entering into behavior change contracts which specify the award of points or other reinforcers upon the residents' achievement of specified behavior change goals within fixed time periods.

Every resident has ample opportunity each day to earn the number of points he needs to maintain himself within the program and to purchase a variety of items and privileges of his choice. The residents who make the most rapid progress toward their individualized treatment goals, of course, have the most points to spend.

Residents spend points for many purposes at the Eufaula Adjustment Center. Noon and evening meals cost five points each. Canteen items range in price from 1 point to

100 points or more. Every effort is made to provide a variety of articles within every price range in the canteen, and special orders are placed for residents who request items not in stock. Special privileges, such as access to the Center's recreational facilities, trips to town, or visits to the beauty shop, can also be purchased with points. The objective is to make available a plentiful and varied supply of attractive reinforcers for which residents will work.

There is no limit to the number of points a resident may accumulate. He can even stockpile his points in a savings account in the Resident Point Bank. The resident has full control over his points. Once he has earned them, they cannot be taken away. Likewise, he can spend only those points he has earned. There are no point "credit cards" or other



Points can be used to purchase special privileges, such as recreational activities or trips to town.

spend-before-you-earn systems at the Center. Although one resident may purchase articles in the canteen for another resident, points cannot be borrowed, lent, or given away. They can be spent only by the resident who earned them.

If a resident loses his point card, he is given another card, but none of the points he had on the lost card are refunded. Just like misplaced money, misplaced points are gone. This procedure is designed to encourage residents to utilize the point bank to safeguard surplus points, and to learn to keep up with their cards.

Saturdays and Sundays are "free days"—points are charged only in the canteen and for special, prescribed activities, but not for meals and routine privileges. As a general rule, no points are awarded on weekends, but the staff is encouraged to award points at any time to reinforce behaviors that are consistent with resident's treatment goals.

As a resident progresses within his treatment program, he can earn the privilege of being placed in a work situation as reinforcement. In keeping with recent court decisions, the residents are paid for their work with money. This mixing of money with points is a confusing element in the token economy, but the problem is a minor one since nothing can be purchased with money at the Center and the nearest community where money is the medium of exchange is approximately seven miles away.

Chapter 3

STAFF DEVELOPMENT[2]

AVAILABILITY OF TRAINED PERSONNEL

It was recognized from the beginning that the Center could not expect to hire highly qualified and experienced mental health professionals in sufficient quantities to administer its programs. Because of the shortage throughout the nation of skilled personnel in the field of mental health, very few, if any, State-operated mental health institutions are optimally staffed. This is particularly true of those institutions whose treatment programs are based upon medically oriented approaches that can be administered only by personnel who have undergone extensive training. Recent action by the Federal court resulted in increased efforts to improve the staff-to-patient ratios in the existing Alabama mental health institutions, placing a further limitation upon the availability of qualified personnel for the newly established Eufaula Adjustment Center. Additionally, the learning-based behavior change concepts upon which the Center's program is based require that those employed in its administration have specialized training that many of the potentially available treatment staff members did not receive when they underwent university training.

For these reasons, a decision was made when the Center was established to rely upon Center resources for the development of all required staff competencies related to the proposed treatment program. Except for the Director, there are no personnel presently employed at the Center who meet the traditional definition of a mental health professional. Yet, as will be seen in a subsequent chapter of this report, the feasibility of employing and training nonprofessional personnel to engage in what might traditionally be considered a highly specialized occupation has proven successful.

STAFF ORGANIZATION AND BACKGROUND

For training purposes, the staff of the Eufaula Adjustment Center has been divided into two major groups: a Primary Treatment Staff group, and a Supportive Treatment Staff group. The responsibility of the Primary Treatment Staff is to engage in the development and administration of treatment programs for the Center's resident population. The Supportive Treatment Staff consists of Center administration, maintenance, and support personnel, such as secretaries, carpenters, and cooks, whose contact with residents is less frequent. The Supportive Treatment Staff is organized around the administrative, maintenance, and support activities that must be performed at the Center or at any other institution of comparable size and function. The division of labor among members of the Primary Treatment Staff is set forth below.

The Primary Treatment Staff is organized generally in response to the need to perform specific program-related functions. For example, each principal program activity,

[2]This chapter includes material presented by John Bilbrey in a Program Report presented at the meeting of the Southeastern Psychological Association in April 1973. For a complete citation, see the Foreword to this report.

such as individually prescribed instruction, work evaluation and vocational assessment, social activities, and physical education, is under the supervision of a Program Manager. His function is to manage the particular activities involved, assure their relevance to treatment program requirements, and see that the various prescriptions for the conduct of treatment activities he receives are carried out in a manner consistent with the particular resident's behavior change goals.

The backbone of the staff is the Behavior Manager. These are the individuals who carry out most of the prescriptions, conduct most of the group and some of the individual program activities, conduct the various individual and group educational sessions, and perform most of the behavioral observation and data collection functions. Because of their key role and continuing contact with residents, most of the Current Notes concerning residents' progress are originated by the Behavior Managers.

The identification of residents' behavior problems, the establishment of behavior change goals, the development of individual programs, and the overall supervision on each resident and the management of his program while he is in treatment are the responsibilities of the Program Analyst. Behavior Managers and Program Managers carry out treatment prescriptions established by Program Analysts. These individuals, in addition to originating problem lists, treatment plans, and prescriptions, conduct most of the individualized behavior therapy and counseling activities required for residents assigned to them.

Very few of the Center's staff members had been exposed to the learning-based behavior change concepts underlying the Center's program prior to their employment. About half of the Program Analysts have bachelor's degrees in psychology. A few have degrees in related fields such as sociology or guidance, others have degrees in unrelated fields such as history or business education, and still others have little or no college training. None have had work experiences that could be considered relevant. The majority have had no prior work experience, but are recent college graduates.

Program Managers, on the other hand, have had training and/or experience that could be considered relevant to the activities they are supervising, but only one has had prior exposure to the application of the behavior change techniques employed at the Center.

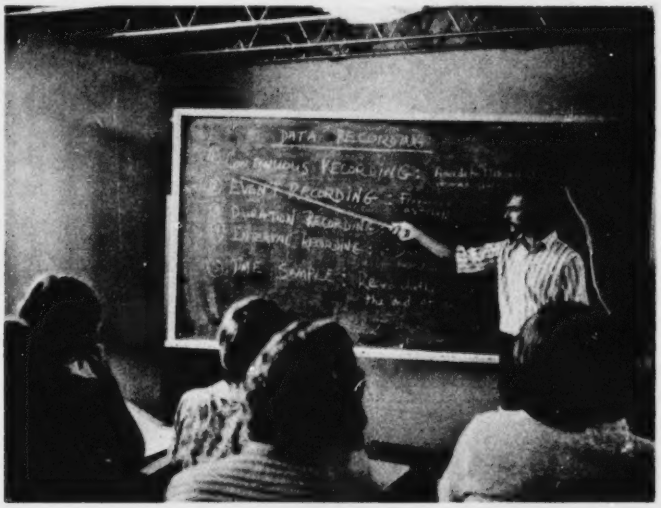
The backgrounds of Behavior Managers vary widely. Some have bachelor's degrees and experience, and have been assigned to specific activities where their training and experience appear most useful. For example, Behavior Managers who are qualified school teachers generally work in the individually prescribed academic instruction program under the supervision of the Program Manager responsible for that program. Others, whose education and experience are more limited, serve as dormitory supervisors and assistants to Program Managers and Program Analysts. Most of the Behavior Managers have completed from 7 to 12 years of school and have had little or no work experience that can be considered directly relevant to the tasks they are performing as members of the Center's Primary Treatment Staff.

By contrast, most members of the Supportive Treatment Staff were employed because they do have education, training, and work experiences relevant to their assigned tasks at the Center. With respect to their performance of these supportive tasks, specific task training is not required.

PRIMARY TREATMENT STAFF DEVELOPMENT

Training for the Primary Treatment Staff consists of an initial three-phase program that prepares nonprofessionals to perform the treatment related tasks required of them

during their employment at the Center, and a continuing education program intended to maintain their specialized skills and to keep them abreast of developments in the technology of behavior change as practiced at the Center.



Members of the Primary Treatment Staff are trained by a three-phase program that prepares non-professionals to perform the treatment-related tasks, and a continuing education program to maintain their specialized skills in behavior change.

The first phase of their initial training, a phase that lasts for approximately two weeks and requires full-time (8 hours per day) participation, is an introductory phase. It constitutes the principal training given to Behavior Managers, and the first phase of training for Program Managers and Program Analysts. It consists of instruction in the principles of behavior management and Center procedures through lectures, discussions, audiovisual presentations, workshop exercises, and reading assignments; conferences with staff members; execution of a behavior change project; observation of on-going treatment activities; supervised work at tasks typically assigned to Behavior Managers; and instruction in the techniques of muscular relaxation.

The second phase consists of selected readings and discussions of those readings with the training staff and with other senior staff members, observation of treatment activities, and, in some instances, additional supervised work as a Behavior Manager. This phase is designed to permit Program Manager and Program Analyst trainees to become familiar with additional literature related to learning-based behavior change techniques and to individually administered behavior therapies. For Program Managers, this constitutes the final phase of their initial training in behavior change techniques, but during this phase, they also are given any specialized, task-related training that will be required of them by virtue of their particular assignments in the treatment program. Approximately two additional weeks of full-time effort are required to complete this training phase.

The third phase of initial Primary Treatment Staff training is designed for Program Analyst trainees, although it is available, in whole or in part, to Program Managers and Behavior Managers with the approval of the Training Director and their immediate supervisor. Upon completion of this phase, Program Analysts are given full-time assignments in the treatment program, where they typically are made responsible for the management and conduct of all aspects of residents' treatment programs. This training is not of fixed duration, but Program Analysts are expected to complete it within six months of their initial employment.

Third phase training consists of instruction in the principal behavior therapy techniques that will be employed by Program Analysts, in addition to techniques included in

earlier phases of training, during their subsequent work with residents. It also consists of supervised conduct of all treatment program activities normally engaged in by Program Analysts, and supervised conduct of all administrative, record keeping, and program support activities of senior staff personnel.

In all three phases, training is individualized in recognition of the ability, previous learning, and learning rate of each trainee. In those cases where economy of time and resources dictate that training be conducted on a group basis, care is taken to assure the timeliness of such training with respect to the completion of relevant study and work assignments by each trainee involved. Frequent use is made of existing textbooks, reports, and journal reprints in this training, as well as commercially available films and tape recordings. These are supplemented by specially prepared presentations by the training staff and by colored slide and closed-circuit television recordings made at the Center.

Heavy emphasis, particularly during the first and third phases, is placed upon hands-on training. Trainees participate in a wide range of behavior change activities, both as treatment program designers and administrators and as treatment recipients. The emphasis throughout is upon gaining experience, rather than merely upon studying about the Center's treatment activities.

There have been a few dropouts in the Primary Treatment Staff initial training program. The course is demanding for individuals who are unaccustomed to exhibiting self-discipline, initiative, and dependability in their work habits. Not everyone learns to be comfortable in the employment of the learning-based techniques used at the Center; it sometimes involves withholding approval from a resident until his behavior is worthy of that approval. But, because each phase of training is individualized and builds upon previously developed skills, most trainees have been able to attain a level of skill consistent with their own goals as well as with the needs of the Center. There is a need within the program for a wide range of staff abilities and skills, and it appears that anyone with initiative and a concern for his fellow man can become a productive member of the Center's Primary Treatment Staff.

Continuing training for the Primary Treatment Staff is evolving. The Center is too new to have had much experience in this area. At the present time, this training consists of presentations by the training staff and by visiting consultants concerning various aspects of the Center's program, review of specified journals and acquisitions in the Center's library, and case reviews among staff members. From time to time, selected staff members attend conferences and workshops sponsored by professional groups or training organizations where they may obtain additional information for their own edification as well as for dissemination to the rest of the staff.

SUPPORTIVE TREATMENT STAFF DEVELOPMENT

Members of the Supportive Treatment Staff are employed primarily to perform the many non-treatment-program specific tasks that are essential to the daily operation of the Eufaula Adjustment Center. As far as the development and administration of residents' treatment programs are concerned, their efforts are supportive rather than primary. Nevertheless, many of these employees have frequent contact with residents and it is essential that their behavior toward and around residents during those contacts be consistent with the residents' behavior change goals.

Training for the Supportive Treatment Staff consists of three principal activities. First, these employees are asked to read selected sections of a commercially available text that provides an elementary introduction to the learning-based behavior change concepts underlying the Center's program, to discuss the contents of these readings with the Training Director, and to pass a short, multiple-choice test covering the readings. The

purpose of this activity is to enable each trainee to discuss the Center's treatment program with other staff members and with the public, to be aware that there is a data base underlying the program, and to conduct himself in accord with residents' treatment goals.

The second activity is a discussion, led by the Training Director, of relevant portions of the Center's Procedures Manual. This is considered necessary so that all staff personnel at the Center will be aware of privileges available to residents as a function of their basic civil rights as well as of the treatment program levels they may have attained.

Finally, the Supportive Treatment Staff participates in a Current Note Writing Workshop. This same workshop is a Phase I training activity for the Primary Treatment Staff. Its objective is to train all Center personnel who may have opportunities to observe residents' behavior to document and communicate in appropriate form (i.e., via Current Note, using behavioral terminology) relevant data concerning such behavior to those responsible for supervision of residents' programs.

The Supportive Treatment Staff training program is designed for group administration. It requires approximately 24 hours to administer, including the time typically required to complete the assigned readings. The program usually is administered at the Center for three hours each day for eight consecutive work days.

Chapter 4

PROGRAM EFFECTIVENESS[3]

DATA ON RESIDENTS DURING INITIAL PERIOD

The first residents were admitted to the Eufaula Adjustment Center in April 1972. The participation of these residents in treatment activities provided opportunities for further staff training and for testing of treatment program concepts. The initial residents were selected from among the adult patient population at Partlow State School, an institution that has served Alabama for many years as a school and hospital for mental retardates. Between April 1972 and March 11, 1973, the cut-off date for the data reported here, 63 residents were admitted to the Center. Of these, 26 had been patients at Partlow up to the time of their admission, 20 had been patients at Bryce Hospital, and 17 came directly from their home communities. Bryce Hospital is one of the two State institutions in Alabama for the treatment of mental illnesses. Searcy Hospital is the other such institution.

Of these 63 residents, 46 were discharged from the Center by the cut-off date or had completed all program activities and were awaiting arrangements for vocational training and placement by the Department of Vocational Rehabilitation, and 17 remained in active programs.

Of the 46 residents who were no longer in active treatment programs, nine either refused or were unable to participate in program activities. Two of these nine had requested discharge within hours of their admission to the Center, and consequently did not engage in any activities. Treatment programs were established for the other seven residents, and they attended at least one activity during their first few days at the Center. Then, however, they engaged in uncontrollable behavior of an aggressive or self-destructive nature which could not be permitted to continue, they requested that they be sent to Bryce or Searcy Hospitals and refused to participate further in the Center's program, or they ran away. Except for one who ran away and has not returned, these residents were admitted directly to Bryce or Searcy Hospitals. None of them remained at the Center for as long as two weeks, and their participation in prescribed activities prior to their departure was infrequent and not in accordance with their program prescriptions.

Thus, after almost one year of operation, the Center had discharged, or was making arrangements to discharge, 37 residents who had participated in activities in accordance with their treatment plans. Except as will be noted later, the present discussion of program effectiveness will deal with these 37 residents.

EVALUATION OF EFFECTIVENESS

Obviously a treatment program as varied as that at the Center cannot be evaluated comprehensively using data on so few subjects. Further, during this early period of

[3] This chapter includes material developed by Connie C. Jones in a Program Report presented at the meeting of the Southeastern Psychological Association in April 1973. For a complete citation, see the Foreword to this report.

operation, the program itself has been evolving rather than static, and the staff administering the program has been in various stages of training. This discussion of program effectiveness must be viewed as nothing more than an early look at the question. It is intended that data similar to those reported here will be reviewed periodically. The larger amounts of data that will be available in the future will permit greater confidence to be placed in any conclusions that might be drawn.

Nevertheless, the consideration of program effectiveness can serve several useful purposes. One purpose is to provide data concerning needs for additional staff training and program modification. Another purpose is to provide guidance to the staff as to the kinds of residents and the kinds of problem behaviors that appear to be best suited for treatment at the Center.

IMPROVEMENT INDEX

In order to explore resident and behavior problem considerations, a measure of treatment program effectiveness is needed. The measure selected for this assessment is the percentage of treatment problems closed. As noted in the description of the Center's treatment program, behavior problems are identified for each resident, a treatment plan is developed for each problem, and following successful treatment, each problem is closed. Thus, the percentage of an individual's problems that have been closed provides a convenient index for that resident of the effectiveness of his treatment program.

For the purpose of an overall evaluation of the Center's treatment program, a three-point Improvement Index was developed, as shown in Table 1. Using the index, an individual is considered "Much Improved" if, following treatment, 75% or more of his behavior problems are closed. He is considered "Moderately Improved" if from 20% to 74% of his behavior problems are closed. If less than 20% of his problems are closed, he is considered "Unimproved."

Table 1

Treatment Program Improvement Index

Much Improved:	75% or more of problems closed
Moderately Improved:	20% – 74% of problems closed
Unimproved:	Less than 20% of problems closed

It should be noted that any improvement short of eliminating an offending behavior would not be recognized in the Improvement Index described here. Thus, should a hypothetical resident engage in an inappropriate behavior five times per day, that problem would not be closed with respect to his treatment program until he discontinued the inappropriate behavior. A reduction in frequency to, say, once a day would not constitute improvement so far as this Index is concerned.

The 37 residents who had completed their treatment program at the Center as of March 11, 1973, had from 2 to 16 behavior problems each for which treatment plans were initiated. The mean number of problems was six. Using the Improvement Index shown in Table 1, 18 of these residents were considered Much Improved, 10 Moderately Improved, and 9 Unimproved. The reason for terminating the treatment programs for each of these residents is indicated in Table 2.

The residents represented in the lower right-hand block of Table 2—residents who were classified as Unimproved and who withdrew from the treatment program against the

Table 2

Basis for Termination of Treatment Program of Discharged Residents

Basis for Termination	Much Improved	Moderately Improved	Unimproved	Total
Treatment Program Completed	16	--	--	16
Treatment Program Incomplete				
Resident's request—staff concur	2	4	--	6
Uncooperative or unmanageable behavior	--	2	3	5
Resident's request—staff non-concur	--	4	6	10
Total	18	10	9	37

recommendation of the staff—were very similar to the seven residents described earlier who were admitted to Bryce or Searcy Hospitals or ran away during the first two weeks of residency. The chief differences were that this latter group of six remained longer and participated more extensively in activities. The treatment program would appear to have been tried but found unsuccessful so far as these six residents were concerned.

EFFECTS OF BACKGROUND CHARACTERISTICS

The relationship between sex of the residents and program effectiveness was investigated. The sex distribution of the 37 former residents, as shown in Table 3, was 22 males and 15 females. On the basis of these limited data, program effectiveness appears to be unrelated to sex.

Age also was investigated, and the residents' age distribution is shown in Table 4. The range of ages was from 14 to 51 years. On the basis of these data, program effectiveness appears to be unrelated to age. In this regard, it should be noted that the original concept of the Center was to deal with young adults only. It is essentially for this reason that there are relatively few residents in the extreme age groups. While data on three residents in the over-35 age group does not justify a conclusion that the Center

Table 3

Treatment Program Effectiveness, by Sex of Resident

Sex	Much Improved	Moderately Improved	Unimproved	Total
Male	13	4	5	22
Female	5	6	4	15
Total	18	10	9	37

Table 4

Treatment Program Effectiveness, by Age of Resident

Age	Much Improved	Moderately Improved	Unimproved	Total
Under 18	4	2	2	8
18 - 35	11	8	7	26
Over 35	3	0	0	3
Total	18	10	9	37

should accept ages above that level, it is interesting to note that all three of those older residents were classed as Much Improved.

The reported level of education of the former residents is shown in Table 5. Educational levels range from no formal education through college. It should be noted that a number of the residents whose educational level was reported to be in the elementary grades had attended ungraded Special Education classes for a number of years, so their reported grade level may require interpretation. Inspection of the data in Table 5 suggests that there may be a relationship between educational level and training program effectiveness, with the program being more effective for the residents with lower educational levels.[4]

Table 5

Treatment Program Effectiveness, by Educational Level of Resident

Educational Level	Much Improved	Moderately Improved	Unimproved	Total
Grades 0-6	13	2	3	18
Grades 7-9	2	3	5	10
Over Grade 9	3	5	1	9
Total	18	10	9	37

$\chi^2 = 12.40, df = 4, p < .02$

The residents under discussion came to the Center from one of three sources: Partlow State School, Bryce State Hospital, or their home communities. The distribution of former residents according to these sources is indicated in Table 6. Inspection of these data suggests that there may be a relationship between source and treatment program

[4] While it is recognized that the number of residents upon whom data are available and the resulting theoretical cell frequencies are lower than would be desirable in the use of such a procedure, a chi-square test was computed on the data in Table 5 and the relationship between educational level and treatment program effectiveness was found to be statistically significant ($p < .02$).

effectiveness, with the program being more effective for former Partlow residents and residents coming from the community than for former Bryce residents.[5]

Table 6

Treatment Program Effectiveness, by Source of Resident

Source	Much Improved	Moderately Improved	Unimproved	Total
Partlow.	13	2	4	19
Bryce	1	5	4	10
Community	4	3	1	8
Total	18	10	9	37

$\chi^2 = 10.35, df = 4, p < .05$

There appears to be a significant relationship between referral source and educational level.[6] Residents from Partlow tended to be less well educated than did residents from Bryce and the community. The distribution of education level by referral source is indicated in Table 7. Inspection of the individual records of residents suggests that there may be important differences in the types of behavior problems presented by Partlow and non-Partlow residents. The problems of Partlow residents more frequently involve behavior related to social niceties such as respecting the rights of others and being able to care for oneself. They appear less frequently to present problems related to drug use or to appear withdrawn, depressed, and overly submissive. At the present time, however, the data available will not permit confident conclusions to be drawn concerning the effect upon treatment program effectiveness of either educational level or referral sources.

Table 7

Educational Level, by Referral Source

Referral Source	Educational Level			Total
	0-6	7-9	>9	
Partlow	16	3	0	19
Bryce	1	5	4	10
Community	1	2	5	8
Total	18	10	9	37

$\chi^2 = 23.44, df = 4, p < .001$

[5]The relationship between source and treatment program effectiveness was found to be statistically significant ($p < .05$).

[6]The relationship between educational level and referral source was found to be statistically significant ($p < .001$).

BEHAVIORS AMENABLE TO MODIFICATION

Analysis of the available data concerning the behaviors most and least amenable to modification can be used to provide guidelines for the Center's treatment program.

It is almost axiomatic in behavior change technology that each behavior should be described uniquely. People working in this field, including the members of the Center's staff, dislike the use of labels or categories when describing behaviors to be changed. Even two well trained Behavior Analysts will not necessarily use the same phraseology in describing the same behavior of the same organism—unless it happens to be within a very narrow range of stereotyped behaviors (such as those exhibited in a Skinner Box). However, unless the various problem behaviors treated at the Center can be categorized in some manner, it will be almost pointless to attempt to predetermine which ones can be treated effectively and which ones cannot.

At the risk of being identified among those who label behaviors instead of modifying them, the task of categorizing the various behavior problems of the Center's past and present residents was undertaken. The 338 behavior problems identified in the records of the 37 former residents and the 17 current residents were sorted, and re-sorted, into categories of seemingly related problems. After final sorting, there were 21 such categories. Four of the categories contained only one behavior problem each, so they were put into one category (easily labeled "miscellaneous"). Thus, altogether, there were 18 categories of behavior problems. A descriptive label was worked out for each category of behavior problems. It is hoped that these labels will communicate the kinds of behavior problems that have been found most and least amenable to treatment during the initial year of Center operation.

The 18 categories of behavior problems identified are listed in Table 8, ordered according to the frequency of their occurrence. Also shown is an index—the percentage of problems that have been closed—of the effectiveness of the treatment program with respect to each problem category. For the most frequent category, for example, 63% of the 65 nonassertive behavior problems noted among residents at the Center have been treated successfully. This category includes such behaviors as withdrawal, submission, crying, and depression.

The right-hand column of Table 8 ranks the 18 categories of behavior problems according to their amenability to treatment at the Center. Thus, categories most likely to be closed following treatment involve such behaviors as inappropriate rationalization and inappropriate body/limb movements, while the problems most resistant to treatment involve drug-related behaviors and aggression.

Four factors should be noted in interpreting the data in Table 8. First, as noted earlier, only closed problems are considered in the table's two right-hand columns. Improvement short of closing a behavior problem altogether is not considered. Second, Table 8 was constructed using data from residents still in active treatment programs. Had the table been limited to data from the completed or discontinued treatment programs of the 37 residents identified in Table 2, the percentages of problems closed would be higher.

Third, 46 of the 63 residents involved had spent significant portions of their lives—39 years in one instance—in institutions where some of the behaviors that were identified at the Center as "problems" had considerable utility for them. These behaviors tend to be much more resistant to change for these formerly institutionalized residents than do comparable behaviors of residents from the community. Finally, many of these formerly institutionalized residents had recollections of unhappiness and conflict during visits outside those institutions and were hesitant to leave the relative comfort and personal security they enjoyed at the Center. There have been instances in which residents have acknowledged deliberate perpetuation of a maladaptive behavior in order

Table 8

Categories of Behavior Problems Occurring Among Residents

Categories of Behavior Problems	Frequency of Occurrence	Closed %	Rank Order Closed
Non-assertive behaviors (e.g., withdrawn, depressed, crying, submissive)	65	63	7
Verbal behavior, content (e.g., aggressive, antagonistic, hypercritical, disruptive, interruptive, generally inappropriate)	57	40	15
Antiestablishment behaviors (e.g., stealing, lying, breaking EAC rules)	40	42	14
Personal hygiene and grooming	24	75	3.5
Sex adjustment and orientation	22	50	11.5
Inappropriate body/limb movements (e.g., tics, mannerisms, involuntary gestures)	18	78	2
Aggression (e.g., physically aggressive, destructive, domineering, intimidating, overbearing)	17	25	17
Social graces (e.g., eating behaviors, manners in general)	16	56	9
Living skills deficiencies (e.g., cooking, budgeting, home management)	15	67	5.5
Health-related behavior (e.g., hypochondriacal, over-eating, regulating own medication)	14	43	13
Phobic behaviors	13	54	10
Attention-seeking, non-verbal (e.g., giving gifts, clinging, gestures, "clowning")	9	33	16
Verbal behavior, rate and intensity	7	57	8
Inappropriate rationalization (e.g., fantasizing, overestimating self-worth)	5	80	1
Drug related behaviors (e.g., narcotics and alcohol withdrawal behaviors, gasoline sniffing)	5	20	18
Behaviors more appropriate to a younger age	4	50	11.5
Miscellaneous behaviors	4	75	3.5
Hoarding behaviors (e.g., stuffing pockets, carrying objects, hoarding)	3	67	5.5
Total	338	52	

to remain in treatment at the Center rather than having to face the outside world. While such residents obviously require further treatment prior to leaving the Center, the effect of such deliberate perpetuation of maladaptive behaviors is to keep behavior problems open that otherwise would be closed and thus possibly distort the data in Table 8.

It would be desirable to draw behavior profiles in much greater detail for those residents who were successfully treated, and for those who were relatively unimproved.

However, there are obvious pitfalls to *post hoc* profiling of groups whose classification was based on the same data from which the profiles would be drawn. Therefore, a more detailed profiling of successfully and unsuccessfully treated groups will not be attempted at this time. As the data accumulate and there are opportunities to cross-validate profiles, resident profiling will be possible. For such profiles to be really useful to the Admissions Committee, however, it will be necessary tc look beyond these basic categories to qualitative differences among behaviors within categories.

Chapter 5

CONCLUSIONS AND PROGRAM CHANGES

PROGRAM CHANGES

It can be stated with some confidence that the Eufaula Adjustment Center's treatment program, as it has evolved during the first year of operation, is generally successful in modifying many of the inappropriate behaviors presented by residents. A substantial proportion of residents are being returned to society better able to function successfully. At the same time, there are behavior problems and resident types for whom the current program is less effective.

During the spring and summer months of 1973, changes have continued to be made in the Center's treatment program in efforts to make it more effective for larger numbers of problems and residents. Many of the changes are in the content of the core curriculum, the short courses, the evening and weekend social activities, the schedules residents follow, and staff organization. Although the concepts underlying the program are under constant review, the basic premises—the maladaptive behaviors are learned responses to an individual's environment rather than manifestations of disease, and that the residents' difficulties in coping with life situations are best ameliorated through learning processes—have not changed. In fact, the evidence continues to mount, in the behavioral research literature as well as at the Center, that this general treatment approach is fundamentally sound and can be expected soon to become the approach of choice at all or nearly all mental health treatment centers.

In addition to changes in program content, the range of treatment activities provided by the Center is being expanded. The expansion of the Center's service is to a large extent a reflection of the present philosophy of the Department of Mental Health. That philosophy is to move toward further development of community alternatives to hospitalization and institutionalization. In carrying out that philosophy, the Center has shifted more of its resources to the application of its treatment concepts to the behavior problems of non-residents. Four areas of such community-oriented activity have been begun or are planned for future initiation. These are Day-Care Programs, Community Placement and Follow-Up, Community Information and Training, and Crisis Intervention.

Day-Care Programs

There are many citizens who are ineligible for admission to the Center as residents because of age or physical disabilities, because they are not functioning at near-average levels of intelligence, or because they do not appear to be employable following treatment or vocational training. Others, for various reasons, do not volunteer for resident status at the Center, but they do wish to avail themselves of various treatment resources of the Center. Where such considerations obtain and the individual resides within convenient commuting distance, he may be accepted for treatment as a non-resident.

The behavior change model described in Chapter 2 is applied to these non-residents, or clients, just as it is to residents. When a client is accepted under the day-care program, behavioral and available case history data are used to develop a list of his behavior problems, and a unique treatment plan is developed for each. These treatment plans may

require the client to participate, along with residents, in existing treatment activities such as short courses, social activities, and individual and small group treatment activities with senior treatment staff personnel. The plans might alternatively, or additionally, involve behavioral counseling with the client's family, having them systematically record behavioral data concerning the client's problems, and, in some instances, restructuring the social environment in which the client lives.

It is possible that this day-care program can be expanded. The possibility of joint efforts to provide services to this clientele is under discussion with nearby community mental health centers. Problems to be resolved relate to the availability of operating funds, staff, and transportation.

Community Placement and Follow-Up

There is an obvious need on the part of many former residents for assistance in their transition back to their communities. Fortunately, many of these individuals are assisted by their families. Others, particularly those who are readily employable or who are placed in vocational training situations, find assistance from their employers, fellow workers, and community-based agencies. There are a few, however, who are not so fortunate, and the Center has found that it must provide them with the necessary assistance. More often than not, these individuals who must be assisted by the Center are of borderline intellectual ability or are in their middle to late teens.

For these individuals, the Center's staff seeks a combination of a temporary home, where they can board, and a job that offers opportunity for on-the-job training. Typically, the specific nature of such jobs is negotiated between the Center staff and the employer, so that the jobs themselves constitute training activities consistent with treatment goals. In cases where the initial productivity of the resident on these jobs is significantly below that of other trainees on comparable jobs, it is sometimes necessary for the Center to guarantee that minimum wage requirements will be met. This can only occur, of course, where the training situation is a part of the resident's treatment program. So far, locating a temporary home has been less of a problem than finding appropriate jobs for residents, since there are many families in Alabama who have opened their homes to residents and voluntarily provided "foster parent" assistance when it was needed.

This particular aspect of the Center's expanding program has been especially well received by all who have participated in it. To the staff, it has presented more flexibility in both treatment program development and placement. To the resident, it has provided places to live and work in communities rather than in residential centers. To the community, it has provided a greater awareness of the Center's program and an opportunity to become involved in it.

Community Information and Training

We perceive a need in the community for better education about the Center's program and its treatment approach. Specific attempts have been made to accomplish this. Presentations describing the Center have been prepared for use with lay groups, and a number of invitations have been accepted from civic and religious groups. A brochure has been distributed, calling the public's attention to the services offered by the Center. This Technical Report constitutes yet another means of providing information about the Center to the public.

Very few resources could be spared during the initial period of Center operation for this program, but more are to ba allocated to it in the future. In addition, it is planned that information will be directed specifically to medical, human resources, and law enforcement professionals when the Center's resources permit. Also, it is planned that

specific training in the management of behavior, training similar to that presently provided to the Center staff, will be made available to both lay and professional groups in an attempt to better equip them to deal with behavior problems within the communities.

Crisis Intervention

No systematic effort has been directed to this area as yet, although, as more people become aware of the Center's existence, the need becomes more apparent. There are frequent calls from both community agencies and families seeking guidance with respect either to behaviors that do not justify admission of the individual concerned to the Center or behaviors of individuals ineligible for admission. Additionally, former residents have found that a brief telephone conversation with staff members familiar with their records at the Center has helped them to deal with situations they faced.

It is our view that the provision of assistance via telephone to professionals, laymen, and former residents can be a valuable extension of the Center's treatment activities into the community. Since these activities are non-medical in nature, a little guidance from someone trained in the behavior change techniques employed at the Center would enable many citizens to better deal with very maladaptive behaviors. If such behaviors, and the situations that engender them, are not changed, it may result in the admission of yet another resident to the Center.

The implementation of crisis intervention services on a systematic basis awaits increases in the Center's resources. In the future, it is expected to be an important part of the Center's community-oriented activity.

IN TRANSITION

Before concluding this report, the authors wish to state their personal view of the present (September 1973) state of the mental health treatment art. It is relatively primitive. The medical model that has been dominant for so long has been subjected to evaluation. At present, behavior change techniques such as those employed at the Eufaula Adjustment Center have been found more suitable and are becoming increasingly popular, and they appear to fare much better when subjected to evaluation—but they too have not yielded fully satisfactory results in all instances. While we believe that these techniques are the best available to the staff for the Center's resident population and probably provide more promise for the future than do other presently available techniques, we do not believe that our quest for more effective treatment approaches should end. We will continue to seek a better answer. There probably will be many. If we are fortunate, we will recognize them, and will adjust the Center's approach accordingly.

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